COMMUNITY HEALTH IMPROVEMENT PLAN

2020 - 2022

Providence Portland Medical Center

Multnomah County, Oregon

To provide feedback about this CHIP or obtain a printed copy free of charge, please email Joseph Ichter, DrPH, at Joseph.Ichter@providence.org

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EXECUTIVE SUMMARY

Improving the health of our communities is a fundamental commitment rooted deeply in our heritage and purpose. As expressions of God's healing love, witnessed through the ministry of Jesus, our Mission calls us to be steadfast in serving all with a special focus on our most poor and vulnerable neighbors. This core belief drives the programs we build, investments we make, and strategies we implement.

Knowing where to focus our resources starts with our Community Health Needs Assessment (CHNA), an opportunity in which we engage the community every three years to help us identify and prioritize the most pressing needs, assets, and opportunities. In the Portland metro area, Providence Portland Medical Center (PPMC) is a member of the Healthy Columbia Willamette Collaborative (HCWC). The collaborative is a unique public-private partnership of 12 organizations in Washington, Clackamas, and Multnomah Counties in Oregon and Clark County in Washington State. HCWC is dedicated to advancing health equity in the four-county region, serving as a platform for collaboration around health improvement plans and activities that leverage collective resources to improve the health and well-being of local communities.

Based on geographic location relative to other hospitals in the area and patient demographics, Multnomah County is PPMC's primary service area. Clackamas, Washington, and Clark (WA) counties are surrounding secondary counties that are primarily served by other area hospitals. The facility and campus includes 483 acute care beds, offering primary and specialty care, birth center with family suites, general and specialty surgery, radiology, diagnostic imaging, pathology and 24/7 emergency medicine. We are recognized for excellence in patient care and research in areas such as cancer, heart, orthopedics, women's health, rehabilitation services and behavioral health. PPMC provided nearly $158 million[1] in Community Benefit in 2019.

As a result of the findings of our 2019 Community Health Needs Assessment (CHNA) and through a prioritization process aligned with our Mission, resources, and hospital strategic plan, PPMC will focus on the following bolded areas for its 2020-2022 Community Benefit efforts:

PRIORITY 1: SOCIAL DETERMINANTS OF HEALTH AND WELLBEING

Focus areas in **housing,** transportation, and **food security; includes coordination of supportive services**.

PRIORITY 2: CHRONIC CONDITIONS

Focus on prevention of **obesity, diabetes, hypertension, and depression.**

PRIORITY 3: BEHAVIORAL HEALTH/WELLBEING AND SUBSTANCE USE DISORDERS

Focus on prevention (particularly for youth**), culturally responsive care and health education**, social isolation, and **community building**.

PRIORITY 4: ACCESS TO CARE

Focus on **services navigation and coordination, culturally responsive care and oral health**.

[1] Unpaid costs of Medicare are included in this Community Benefit reporting.

Responding to the COVID-19 Pandemic

The 2020 Community Health Improvement Planning (CHIP) process was disrupted by the SARS-CoV-2 virus and COVID-19, which has impacted all of our communities. While we have focused on crisis response, it has required a significant re-direction of resources and reduced community engagement in the CHIP process.

This CHIP is currently designed to address the needs identified and prioritized through the 2019 CHNA, though COVID-19 will have substantial impacts on our community needs. These impacts are likely to exacerbate some of the needs identified, and cause others to rise in level of priority. While this is a dynamic situation, we recognize the greatest needs of our community will change in the coming months, and it is important that we adapt our efforts to respond accordingly. Additionally, the data projections included were crafted based on data collection and project forecasting done prior to the COVID-19 pandemic, so may be modified as we understand adjusted resources and priorities within our communities in the aftermath of the pandemic.

This CHIP will be updated by March 2021 to better document the impact of and our response to COVID-19 in our community. We are committed to supporting, strengthening, and serving our community in ways that align with our Mission, engage our expertise, and leverage our Community Benefit dollars in the most impactful ways.

MISSION, VISION, AND VALUES

Our Mission	As expressions of God's healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable.
Our Vision	Health for a Better World.
Our Values	Compassion — Dignity — Justice — Excellence — Integrity

INTRODUCTION

Who We Are

Portland Providence Medical Center (PPMC) is an acute-care hospital founded in 1941 and located in Portland, Oregon. The hospital has 483 licensed beds. PPMC has a staff of more than 3,100 and professional relationships with more than 1,200 local physicians. The facility and campus include 483 acute-care beds, offering primary and specialty care, a birth center with family suites, general and specialty surgery, radiology, diagnostic imaging, pathology, and 24/7 emergency medicine. It is recognized for excellence in patient care and research related to cancer care, heart health, orthopedics, women's health, rehabilitation services, and behavioral health.

Our Commitment to Community

PPMC dedicates resources to improve the health and quality of life for the communities it serves, with special emphasis on the needs of the economically poor and vulnerable. During 2019, PPMC provided nearly $158 million in community benefit[2] in response to unmet needs and to improve the health and well-being of those it serves in the Portland metro area.

Community Benefit Governance and Management Structure

PPMC further demonstrates organizational commitment to the community benefit process through the allocation of staff time, financial resources, and participation and collaboration with community partners. The Community Health Division, in collaboration with PPMC leadership, is responsible for coordinating implementation of state and federal 501r requirements as well as providing the opportunity for community leaders and internal hospital executive leadership members, physicians and other staff to work together in planning and implementing the Community Health Improvement Plan.

As a primary source of Community Benefit advice and local leadership, PPMC's Service Area Advisory Council (SAAC) plays a pivotal role to support the Board of Trustees in overseeing community benefit issues. Acting in accordance with a Board-approved charter, the SAAC is charged with identifying policies and programs that address identified needs in the service area particularly for underserved populations, overseeing development and implementation of the Community Health Needs Assessment and Community Health Improvement Plan Reports, and overseeing and directing the Community Benefit activities. The SAAC delegates some work to the Community Benefit Committee, a majority of members

[2] A community benefit is an initiative, program or activity that provides treatment or promotes health and healing as a response to identified community needs and meets at least one of the following community benefit objectives: a. Improves access to health services; b. Enhances public health; c. Advances increased general knowledge; and/or d. Relieves government burden to improve health. Note: Community benefit includes both services to the economically poor and broader community. To be reported as a community benefit initiative or program, community need must be demonstrated. Community need can be demonstrated through the following: 1) community health needs assessment developed by the ministry or in partnership with other community organizations; 2) documentation that demonstrates community need and/or a request from a public agency or community group was the basis for initiating or continuing the activity or program; 3) or the involvement of unrelated, collaborative tax-exempt or government organizations as partners in the community benefit initiative or program.

who have knowledge and experience with the populations most likely to have disproportionate unmet health needs. The Community Benefit Committee generally meets quarterly.

Planning for the Uninsured and Underinsured

Our mission is to provide quality care to all our patients, regardless of ability to pay. We believe that no one should delay seeking needed medical care because they lack health insurance. That is why PPMC has a Financial Assistance Program (FAP) that provides free or discounted services to eligible patients. The following provides an overview of the program:

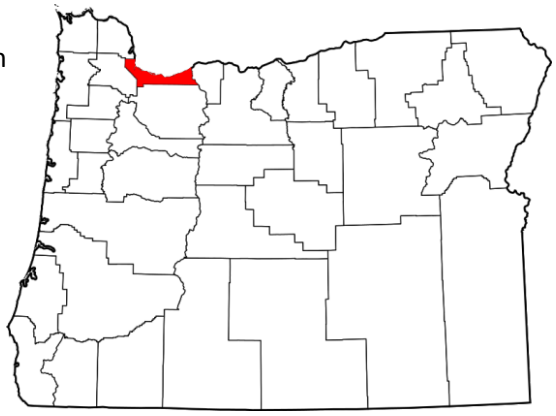
- 100% financial assistance is provided for households making up to 300% FPL
- 75% financial assistance for households between 301% and 400% FPL
- Financial assistance applies to self-pay balances and patient responsibility balances after insurance pays.

One way PPMC informs the public of FAP is by posting notices. Notices are posted in high volume inpatient and outpatient service areas. Notices are also posted at locations where a patient may pay their bill. Notices include contact information on how a patient can obtain more information on financial assistance as well as where to apply for assistance. These notices are posted in English and Spanish and any other languages that are representative of 5% or greater of patients in the hospital's service area. All patients who demonstrate lack of financial coverage by third party insurers are offered an opportunity to complete the Patient Financial Assistance Application and are offered information, assistance, and referral as appropriate to government sponsored programs for which they may be eligible. For information on our Financial Assistance Program click here.

OUR COMMUNITY

Description of Community Served

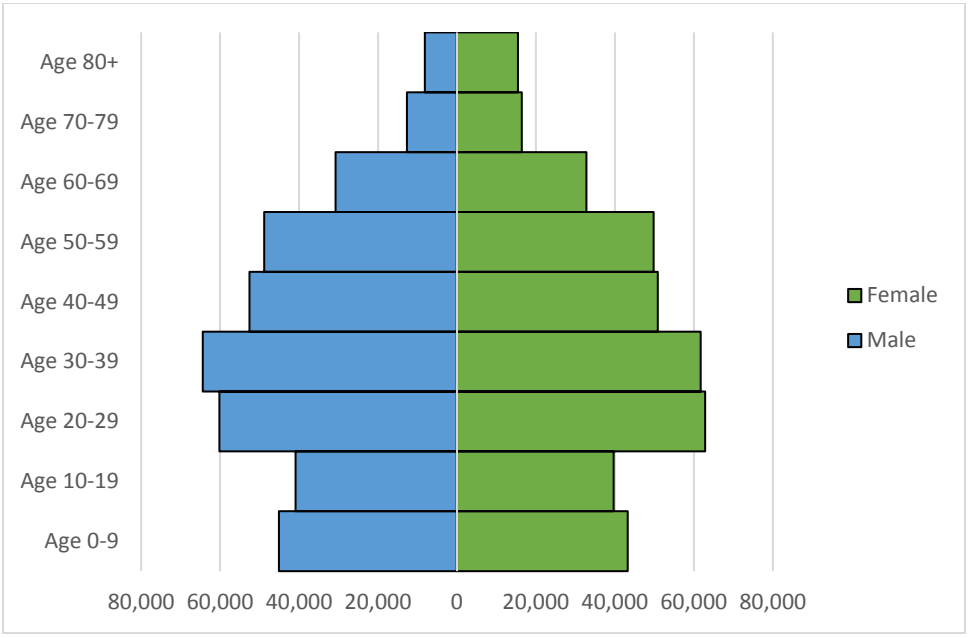
Based on geographic location relative to other hospitals in the area and patient demographics, Multnomah County (in red) is PPMC's primary service area. Neighboring Clackamas, Washington, and Clark (WA) counties, are considered secondary service areas that are primarily served by other area hospitals.



Population and Demographics

The current population of Multnomah County is over 812,000 people according to 2019 Census data, representing an increase of over 10 percent in population since 2010. Multnomah County has been diversifying, with the foreign-born population increasing nearly 20 percent since 2005, and the Latino population increasing about 62 percent from 2000 to 2010.

Figure 1: 2018 Multnomah County by Age and Gender



The male-to-female ratio is approximately 1:1 until age 65, when females become a greater proportion of the population. This difference is clearest over the age of 85, where there are slightly more than 2 surviving females for each male. Multnomah County is the most populated county in the Portland metro area, with the greatest proportion of individuals between the ages of 25 and 44 compared to other area counties.

Ethnicity

Multnomah County is more racially and ethnically diverse than Oregon as whole. Among Multnomah County residents in 2019, 69.3 percent identified as White non-Hispanic, 11.7 percent were Hispanic or Latino, 8.1 percent Asian or Pacific Islander, 6.1 percent were African American or Black, 1.4 percent were Alaska Native or American Indian, and 4.7 percent identified as two or more races.

Income

In 2019, the median household income for Multnomah County was $64,337, more than $4,000 above the national average. Multnomah County's unemployment rate was 4 percent in August 2019. The state's overall unemployment rate was 4.4 percent, compared to the national average of 3.8 percent at the same time.

Health and Wellbeing

In Multnomah County, 23.4 percent of adults are considered obese, and 26.9 percent of eighth grade students and 27.5 percent of eleventh grade students are either overweight or obese according to 2017 BRFSS data and the 2019 Oregon Healthy Teens Survey. Diabetes and hypertension remain the top two reasons uninsured adults access the Emergency Department for conditions that could be managed in a primary care setting. Over 26 percent of adults suffer from depression and 21 percent report binge drinking according to 2017 BRFSS data.

COMMUNITY NEEDS AND ASSETS ASSESSMENT PROCESS AND RESULTS

Summary of Community Needs Assessment Process and Results

In the Portland Metropolitan area, PPMC is a proud member of the Healthy Columbia Willamette Collaborative (HCWC), a public-private partnership that brings together seven hospital systems, four county health departments, and one coordinated care organization to produce a shared regional needs assessment. The complete assessment for the four-county region was completed July 31, 2019. Across the HCWC region, collected information included county public health data regarding health behaviors, morbidity, and mortality; hospital utilization and CCO data for the uninsured and members of the Oregon Health Plan; and community engagement activities that included 18 listening sessions, four town halls, a literature review, and a community health survey with over 3,600 responses. A detailed list is available from page 85 of the full CHNA (available here).

Identification and Selection of Significant Health Needs

The prioritized needs were chosen based on various community health data and identifiable gaps in available care and services. These health needs were those that had worsened over time, are worse than the state or national average, or have a disproportionate impact on those who are low-income, communities of color, or otherwise marginalized populations. In the course of our work, we determined that emphasis on these needs would have the greatest impact on the community's overall health with significant opportunities for collaboration. These interventions will be prioritized based upon relative needs and opportunities, particularly those that serve identified high needs ZIP codes and neighborhoods including low-income and minority populations.

Community Health Needs Prioritized

The list below summarizes the significant health needs identified through the 2019 Community Health Needs Assessment process:

SOCIAL DETERMINANTS OF HEALTH AND WELL-BEING

- **Affordable housing** (or housing accessibility) is a major challenge for low and moderate income families in the area, particularly for those in recovery from substance use disorder. In Multnomah County 45 percent of households are considered cost-burdened, meaning they spent 30 percent or more of their monthly income on rent. Gentrification continues to perpetuate racism and drive people out of their communities.
- A key barrier for many of Oregon's families continues to be **healthy food access**. More than half

of the state's students are on free or reduced price lunch, and 54 percent of students in Multnomah County qualify. Because nutrition is closely linked with oral health and chronic conditions, improving access to healthy food could lead to improved health outcomes in these other areas.

- Economic development and **living-wage jobs** are key opportunities to improve the health and well-being of our communities. Listening session participants with low incomes described having to make difficult choices between paying for food, utilities, rent, and medical care. Adverse experiences and trauma are more likely in low-income households, particularly those in which the parents are stressed about resources. This also speaks to the challenge in Oregon of the "benefits cliff," whereby public benefits phase out quickly as family income increases, although the increase may not be great enough for self-sufficiency.
- **Transportation** is a challenge for some populations, particularly for the elderly and those living in rural areas. Community members living closer to the central Portland metro area noted that consistent public transportation is a strength; those living farther away from central locations communicated a need for more transportation options. Community members also noted the difficulty of navigating the "last mile" between their transit stop and their final destination. This gap can be especially challenging for community members with mobility challenges.

CHRONIC CONDITIONS

- **Diabetes** continues to be one of the top reasons uninsured adults seek care in the Emergency Department, though the condition is likely better managed in a primary care setting. This suggests opportunities regarding prevention, education, and nutrition support. Diabetes is more common in Medicare recipients than in those who are privately insured.
- **Obesity** is a public health challenge, for both youth and adults. 23.4 percent of Multnomah County's adult population is obese, lower than Oregon's overall percentage of 28.6 percent according to BRFSS. The current generation of youth may be the first to have a shorter life expectancy than their parents due to complications from obesity and its associated conditions.

COMMUNITY MENTAL HEALTH/WELLBEING AND SUBSTANCE USE DISORDERS

- **Access to mental health services** remain a barrier for many community members. There is a need to reduce stigma associated with mental health treatment and increase availability of providers and treatment services. This is particularly true amongst youth and adolescents, presenting opportunities to partner with school-based health centers. Barriers to mental health services are more acute for non-English speakers.
- Access to **substance use treatment** continues to be a challenge for many. This includes alcohol and drug addiction services, both residential and outpatient treatment options. Oregon has relatively high rates of death from drug overdose, drug use (heroin, methamphetamines, and narcotics), and binge drinking.
- As we continue to learn about adverse childhood experiences (ACES) and the impacts of trauma on health later in life (i.e. child abuse, neglect, domestic violence, sexual assault, etc), increasing **community resilience** and preventing exposure to these events in the first place has become increasingly important.

ACCESS TO CARE

- Timely and consistent access to **primary care** remains a challenge, particularly for those on the Oregon Health Plan (Medicaid) and individuals that are uninsured. Data suggest that the number of providers across the region varies based on location, and more than 10 percent of the population in the quad-county area reported not being able to access health care services due to cost.
- **Dental** conditions are among the top preventable reasons uninsured individuals access the Emergency Department, which is rarely the best point of care for these conditions. This presents an opportunity for prevention education and increasing access to preventive services.
- It is important that community members feel welcome, safe, and respected in health care settings. Participants in town halls and listening sessions noted that providers lack the bilingual and bicultural backgrounds necessary to serve the community. Hispanic/Latino community members described being turned away by providers because of discrimination due to lack of insurance and language barriers. A crucial step in improving the health and well-being of communities of color is increasing access to **culturally-responsive care**.

Needs Beyond the Hospital's Service Program

No hospital facility can address all of the health needs present in its community. We are committed to continuing our Mission through Community Benefit grant-making and ongoing partnerships in our community.

While we strive to care for our communities each day, we recognize that we cannot address all needs effectively or independently. For example, we simply will not have enough resources to solve to the housing crisis in the Portland Metro area. However, by selecting specific strategies such as navigation to housing services and working with other foundations and health systems to collaboratively fund supportive services, we believe we can make an impact. In addition, there are two new elements to mental health/wellbeing & substance use disorders on the CHNA this cycle: social isolation and youth prevention. We will dedicate time to explore and build strategies to address these crucial needs in the first year of this CHIP cycle.

However, we are confident that these needs will be addressed by others in the community. For instance, our partnership with Meals on Wheels People in the Portland metro area not only offers healthy meals to address food insecurity, but also an avenue for seniors experiencing social isolation to connect with one another.

PPMC will continue to collaborate with local organizations that address aforementioned community needs to coordinate care and referrals to address these unmet needs. We strongly believe that together we can better address the needs of our communities by leveraging our collective strengths.

COMMUNITY HEALTH IMPROVEMENT PLAN

Summary of Community Health Improvement Planning Process

A CHIP planning committee of hospital leaders, Service Area Advisory Council members and community partners was formed to provide input in the PPMC CHIP process. Due to the 2020 COVID-19 pandemic, the original CHIP process was altered to accommodate a travel ban, social distance requirements, and unforeseen time commitments of key leaders. Below are the altered steps taken to compete the 2020-2022 PPMC CHIP:

- Providence Community Health Division (CHD) staff drafted four CHIP initiatives, including community needs and goals, to present to the CHIP planning committee for input
- In collaboration with community partner organizations, CHD staff drafted the PPMC CHIP to present to hospital leadership and the CHIP planning committee for input
- Input was gathered and incorporated into the final PPMC CHIP document
- Final PPMC CHIP document was approved by PPMC hospital and system level leadership

PPMC anticipates strategies may change and certain community health needs may become more pronounced, requiring changes to the initiatives identified below.

Addressing the Needs of the Community: 2020- 2022 Key Community Benefit Initiatives and Evaluation Plan

INITIATIVE #1: HOUSING NEEDS IN THE PORTLAND METRO AREA

Community Need Addressed

Social determinants – Housing

Goal (Anticipated Impact)

Increase access to permanent and supportive housing

Scope (Target Population)

Unhoused individuals in the Portland metro Area

Table 1. Outcome Measures for Addressing Housing

Outcome Measure	Baseline	FY20 Target	FY22 Target
Increase # of referrals to housing for patients/families in Portland Metro area	485 referrals (Multnomah County)	10% increase from baseline	20% increase from baseline
Increase funding for Supportive Housing Services in Portland metro area	$100,000	$200,000	$300,000

Table 2. Strategies and Strategy Measures for Addressing Housing

Strategy(ies)	Strategy Measure	Baseline	FY20 Target	FY22 Target
Partner with Transition Project's Health Connections program	# of patients experiencing homelessness referred to Health Connections Program	115	TBD	TBD
Health Connections program to place patients in permanent housing	% of referrals that are connected to permanent housing	51%	60%	TBD
Better Outcomes through Bridges (BOB) outreach workers screen PPMC ED patients for housing – related needs	% of BOB patients screened for housing needs (maintaining current programming)	100%	100%	100%
Partner with Impact NW to connect families in need to appropriate housing resources through the Community Resource Desks	% of clients successfully connected to housing resources post-30 day intake *(i.e. Section 8, rental assistance, navigating landlord relationships, placement in shelter)*	26%	30%	36%

Regional Supportive Housing Fund	Providence participates in the Regional Supportive Housing Fund, partnering with health system and foundation funders	Collaborative initiated, convener and financial sponsor identified	Funding sources and amounts determined	Two grants released to community
Providence Health & Services Housing Strategy Workshop	Increase housing units with supportive services available for individuals and families with low income	Community Health Division participates in housing workshop to define goals	150 units planned	150 units available 150 additional planned

Evidence Based Sources

Health Affairs: https://www.healthaffairs.org/do/10.1377/hpb20180313.396577/full/

Permanent Supportive Housing: Evaluating the Evidence for Improving Chronic Homelessness: https://www.ncbi.nlm.nih.gov/books/NBK519591/

Resource Commitment

Community benefit funds, operational funds, foundation funds, outside grant dollars, Community Resource Desk administrative support, BOB outreach worker time.

Key Community Partners

Transition Projects, Central City Concern, Project Access NOW, Multnomah County and City of Portland Joint Office on Homelessness, Impact NW, Health Share of Oregon, Do Good Multnomah, Agape Village, Metropolitan Alliance for the Common Good – Multnomah County Housing Team, Oregon Community Foundation, Meyer Memorial Trust, CareOregon, Cambia Health, Collins Foundation, Legacy Health, Oregon Health & Sciences University, Kaiser Permanente.

INITIATIVE #2: ACCESS TO HEALTH SERVICES

Community Need Addressed

Access to culturally responsive health services, coordination and navigation

Goal (Anticipated Impact)

Increase connection to medical and oral health services for un- and under-insured individuals.

Scope (Target Population)

Un- and under-insured individuals in the Portland metro area

Table 3. Outcome Measures for Addressing Access to Health Services

Outcome Measure	Baseline	FY20 Target	FY22 Target
Increase number of physical health screenings for the Latinx community	408 screenings	288* screenings	TBD
Increase access to oral health services for un- and underinsured	1,276 patients	5% increase from baseline	10% increase from baseline

**Numbers for FY2020 are lower due to inability to conduct screenings through the Promotores Program due to COVID-19 in the March-June 2020 period. Similar circumstances are noted with (due to COVID-19)*

Table 4. Strategies and Strategy Measures for Addressing Access to Health Services

Strategy(ies)	Strategy Measure	Baseline	FY20 Target	FY22 Target
Promotores & Multnomah County Parishes host Telehealth Clinics	# of telehealth clinics	9	7 *(due to COVID-19)*	TBD
Partner with Pacific University mobile oral health services	# of patients seen at mobile clinics	161	150 *(due to COVID-19)*	175
Partner with Medical Teams International to provide mobile emergency dental services	# of patients seen at mobile clinics	1,112	1,167	1,223
Pacific University promotes follow-up for preventive oral health services	# of patients that made follow-up appointments for oral health services	35	30 *(due to COVID-19)*	40

Evidence Based Sources

National Association and Territorial Health Officials, Clinical to Community Connections and Evidence of CHW Effectiveness: https://www.astho.org/Programs/Clinical-to-Community-Connections/Documents/CHW-Evidence-of-Effectiveness/?utm_campaign=enews20200305&utm_medium=email&utm_source=govdelivery.

Oral Health in America: Oral Health in America: A Report of the Surgeon General. Source: Division of Oral Health, National Center for Chronic Disease Prevention and Health Promotion

Resource Commitment

Community benefit funding, community volunteers/Promotores, Providence Nurse Practitioner time, telehealth platform, parish space, Medical Teams International dental van, Pacific University dental van.

Key Community Partners

Promotores, Portland-area parishes, Pacific University School of Hygiene, Familias en Accion, Medical Teams International, Virginia Garcia.

INITIATIVE #3: MENTAL HEALTH & SUBSTANCE USE DISORDERS

Community Need Addressed

Community mental health/well- being and substance use disorders – culturally responsive care and health education, community building.

(Anticipated Impact)

Increase access to culturally responsive behavioral health education and access to care.

Scope (Target Population)

Individuals with low-income in need of access to mental health & substance use services.

Table 5. Outcome Measures for Addressing Mental Health/Well-being & Substance Use Disorders

Outcome Measure	Baseline	FY20 Target	FY22 Target
Increase connection to mental health and substance use disorder services and education	582 individuals reached by outreach and education activities	20% increase of baseline	25% increase of baseline

Table 6. Strategies and Strategy Measures for Addressing Access to Health Services

Strategy(ies)	Strategy Measure	Baseline	FY20 Target	FY22 Target
Partner with Pacific University (PU) for community events on behavioral health for Latinx community – "charlas"	# of people reached by PU activities	485	1000	2000
Un- and Under-insured Latinx community members referred to mental health services at Pacific University and NW Catholic Counseling Services	# of people referred to mental health services in community	51	10% increase	20% increase
BOB patients are screened for Mental Health needs	% of patients in ER engaged in BOB services screened for mental health services (maintaining current programming)	100%	100%	100%
BOB patients screened for substance use treatment needs	% of patients in ER engaged in BOB services screened for substance use disorders (maintaining current programming)	100%	100%	100%

Evidence Based Sources

"Tackling The Mental Health Crisis In Emergency Departments: Look Upstream For Solutions, " Health Affairs Blog, January 26, 2018.DOI: 10.1377/hblog20180123.22248

Community-Defined solutions for Latino Health Care Disparities: https://health.ucdavis.edu/crhd/pdfs/resources/Community_Defined_Solutions_for_Latino_Mental_Health_Care_Disparities.pdf

Oregon Commission on Hispanic Affairs, Latinx Mental Health Research: https://www.oregon.gov/hispanic/Pages/index.aspx

Resource Commitment

Community benefit funds, operational funds, outside grant sources.

Key Community Partners

Pacific University School of Psychology, Central City Concern, Cascadia BHC, Lifeworks NW, Sequoia, NW Catholic Counseling Center, NAMI, OHSU Harm Reduction and Bridges to Care, Multnomah County, Recovery Works NW.

INITIATIVE #4: PREVENTING CHRONIC HEALTH CONDITIONS

Community Need Addressed

Chronic health conditions – focus on prevention of obesity, diabetes, hypertension, and depression.

Goal

Reduce the burden of chronic disease in the Portland metro area.

Scope (Target Population)

Portland metro area families and individuals that are low-income and/or at-risk or have diabetes.

Table 7. Outcome Measures for Preventing Chronic Health Conditions

Outcome Measure	Baseline	FY20 Target	FY22 Target
Healthy body mass index (BMI) for 8th grade youth in Multnomah County [3]	71.1% of 11th grade youth healthy body mass	72% of 11th grade youth have healthy body mass	74% of 11th grade youth have healthy body mass
Diabetes prevalence of Multnomah County adults[4]	7.9%	7.7%	TBD

[3] Measured by bi-annual Multnomah County's Oregon Healty Teens Survey. Baseline is 2019 data.

[4] Oregon Health Authority, Diabetes Prevelance by County. Baseline is 2014-2017 data.

Table 8. Strategies and Strategy Measures for Addressing Chronic Disease

Strategy(ies)	Strategy Measure	Baseline	FY20 Target	FY22 Target
Identify Providence Medical Group clinic champions to promote healthy behaviors with 5-2-1-0+9 messaging	# of Providence Medical Group clinic champions identified	1	10	20
Fund community partners to alleviate food insecurity among youth (Healthier Kids, Together community partners)	# of youth served by community partners to address food insecurity *(see partners listed below)*	440,030	500,000	550,000[5]
Increase number of Diabetes Prevention Program (DPP) cohorts offered near PPMC	# of individuals participating in DPP	45	90	165

Evidence Based Sources

"The National Diabetes Prevention Program (National DPP) is a partnership of public and private organizations working to prevent or delay type 2 diabetes. Partners make it easier for people at risk for type 2 diabetes to participate in evidence-based lifestyle change programs to reduce their risk of type 2 diabetes." **https://www.cdc.gov/diabetes/prevention/index.html**

Addressing Childhood Obesity: Opportunities for Prevention Pediatr Clin North Am. 2015 Oct; 62(5): 1241–1261.

Resource Commitment

Community benefit funds, foundation funds, provider time, promotional materials for 5.2.1.0+9

[5] Gross estimate for youth reached by Heathier Kids, Together funded partners. In 2022, Providence's HKT funded initiatives will wind down.

Key Community Partners

Oregon Food Bank, Partners for a Hunger Free Oregon, Growing Gardens.

Other Community Benefit Programs

Table 9. Other Community Benefit Programs in Response to Community Needs

Initiative (Community Need Addressed)	Program Name	Description	Target Population (Low Income, Vulnerable or Broader Community)
1. Mental Health/Wellbeing & Substance Use Disorders – social isolation	Meals on Wheels People	Social connection through shared meals at Elm Street Court	Seniors and people with disabilities experiencing social isolation and low income.
2. Social Determinants of Health – Food Insecurity	Meals on Wheels People	Meals served at Elm Street Court and people in need discharged with meals from hospital	Seniors and people with disabilities experiencing food insecurity.
3. Social Determinants of Health - All	Impact NW Community Resource Desks	Embed a high-functioning community based organization in Providence medical centers, clinics to address social needs	Individuals and families who have unmet social needs
4. Mental Health/Wellbeing & Substance Use Disorder – prevention & community building	Immigrant and Refugee Community Organization Community Health Worker	Embed Community Health Worker trained in mental health support with clinical supervision in Earl Boyle's elementary school in Portland area.	Immigrant and low-income families in East Portland.
5. Mental Health/Wellbeing & Substance Use Disorders –	Providence Zero Suicide initiative	Implement a tiered-system wide approach to prevent suicide deaths for patients seeking care at Providence	All individuals seeking care at Providence

prevention and access			
6. Social Determinants of Health – Housing	Catholic Charities, Providence & Arch Diocese Healthy Housing Initiative	House individuals experiencing homelessness	Chronically homeless population in Portland Oregon
7. Social Determinants of Health – Transportation	Ride Connection	Transportation to medical appointments and necessary errands	Seniors and people with disabilities who have limited access to transportation

2020-2022 CHIP GOVERNANCE APPROVAL

This Community Health Improvement Plan was adopted on May 4th, 2020, by the PPMC Service Area Advisory Council. The final report was made widely available[6] by May 15, 2020.

Krista Farnham 5·4·2020

Krista Farnham — Date
Chief Executive, PPMC and Eastern Oregon Division

Lisa Vance May 8, 2020

Lisa Vance — Date
Chief Executive, Oregon Region

Joanne Warner May 8, 2020

Joanne Warner — Date
Chair, Oregon Community Ministry Board

May 11, 2020

Joel Gilbertson — Date
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To request a copy free of charge, provide comments, or view electronic copies of current and previous Community Health Improvement Plans please email CommunityBenefit@providence.org.

[6] Per § 1.501(r)-3 IRS Requirements, posted on hospital website

APPENDICES

Appendix 1: Definition of Terms

Community Benefit: An initiative, program or activity that provides treatment or promotes health and healing as a response to identified community needs and meets at least one of the following community benefit objectives:

a. Improves access to health services;
b. Enhances public health;
c. Advances increased general knowledge; and/or
d. Relieves government burden to improve health.

Community benefit includes services to persons living in poverty, persons who are vulnerable, and the broader community.

To be reported as a community benefit initiative or program, community need must be demonstrated. Community need can be demonstrated through the following:

a. Community health needs assessment developed by the ministry or in partnership with other community organizations;
b. Documentation that demonstrates community need and/or a request from a public agency or community group was the basis for initiating or continuing the activity or program; or
c. The involvement of unrelated, collaborative tax-exempt or government organizations as partners in the community benefit initiative or program.

Health Equity: Healthy People 2020 defines *health equity* as the "attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities."

Social Determinants of Health: Powerful, complex relationships exist between health and biology, genetics, and individual behavior, and between health and health services, socioeconomic status, the physical environment, discrimination, racism, literacy levels, and legislative policies. These factors, which influence an individual's or population's health, are known as *determinants of health*. *Social determinants of health* are conditions in the environment in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Initiative: An initiative is an umbrella category under which a ministry organizes its key priority efforts. Each effort should be entered as a program in CBISA Online (Lyon Software). Please be sure to report on all your Key Community Benefit initiatives. If a ministry reports at the initiative level, the goal (anticipated impact), outcome measure, strategy and strategy measure are reported at the initiative level. Be sure to list all the programs that are under the initiative. Note: All Community Benefit initiatives must submit financial and programmatic data in CBISA Online.

Program: A program is defined as a program or service provided to benefit the community (in alignment with guidelines) and entered in CBISA Online (Lyon Software). Please be sure to report on all community benefit programs. Note: All community benefit programs, defined as "programs", are required to include financial and programmatic data into CBISA Online.

Goal (Anticipated Impact): The goal is the desired ultimate result for the initiative's or program's efforts. This result may take years to achieve and may require other interventions as well as this program. (E.g. increase immunization rates; reduce obesity prevalence.).

Scope (Target Population): Definition of group being addressed in this initiative: specific description of group or population included (or not included, if relevant) for whom outcomes will be measured and work is focused. Identify if this initiative is primarily for persons living in poverty or primarily for the broader community.

Outcome measure: An outcome measure is a quantitative statement of the goal and should answer the following question: "How will you know if you're making progress on goal?" It should be quantitative, objective, meaningful, and not yet a "target" level.